Pelvic Screening Examination

Overview

A pelvic screening examination is an important part of preventive health care for all adult women. A pelvic examination is performed to help detect precancers, genital cancers, infections, Sexually Transmitted Diseases (STDs), other reproductive system abnormalities, and genital and vaginal problems. STDs in women may be associated with cervical cancer. In particular, one STD, Human Papillomavirus (HPV), causes genital warts, and cervical and other genital cancers. The pelvic examination is also used to help find fibroids or ovarian cancers, as well as to evaluate the size and position of a woman's pelvic organs.

A pelvic examination can also be used as a prevention tool for detecting, preventing, and treating bladder cancer. Bladder cancer is the tenth most frequent cancer diagnosed in women.[7] In addition, a Medicare pelvic screening examination includes a breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and/or cancer.

Fortunately, when many of the illnesses are diagnosed and treated early, they can be slowed or halted. The pelvic screening examination benefit offered by Medicare can help beneficiaries maintain their general overall health of the lower genitourinary tract.

Medicare's coverage of the screening pelvic examination was created as a result of the implementation of the Balanced Budget Act of 1997 (BBA). The BBA includes coverage of a screening pelvic examination for all female beneficiaries, effective January 1, 1998.

Risk Factors

The high risk factors for cervical and vaginal cancer categories are:

Cervical Cancer High Risk Factors

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease [including Human papillomavirus and/or Human Immunodeficiency Virus (HIV) infection]
- Fewer than three negative Pap tests within the previous seven years

Vaginal Cancer High Risk Factors

- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Coverage Information

Medicare provides coverage of a screening pelvic examination for all female beneficiaries when performed by a doctor of medicine or osteopathy, or by a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist who is authorized under State law to perform the examination (this examination does not have to be ordered by a physician or other authorized practitioner). Frequency of coverage is provided as follows:

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[7] The American Cancer Society, Inc. January 1, 2004. *Detailed Guide: Bladder Cancer* [online]. Atlanta, GA: The American Cancer Society, Inc., 2004 [cited 1 October 2004]. Available from the World Wide Web: (*www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_bladder_cancer_44.asp?rnav=cri*).

Covered once every 12 months:

Medicare provides coverage of a pelvic screening examination annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered pelvic examination was performed) for beneficiaries that meet one (or both) of the following criteria:

- There is evidence that the woman is in one of the high risk categories (previously identified) for developing cervical or vaginal cancer, other specified personal history presenting hazards to health and at least 11 months have passed following the month that the last covered pelvic screening examination was performed.
- A woman of childbearing age had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during the preceding 3 years.

Who Are Qualified Physicians and Non-Physician Practitioners?

Pelvic screening examination is covered when performed by a doctor of medicine or osteopathy, or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist), who is authorized under State law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

Covered once every 24 months:

Medicare provides coverage of a pelvic screening examination for all asymptomatic female beneficiaries every two years (i.e., at least 23 months have passed following the month in which the last Medicare-covered pelvic examination was performed).

Medicare's covered pelvic examination includes a complete physical examination of a woman's external and internal reproductive organs by a physician or qualified non-physician practitioner. In addition, the pelvic examination includes a clinical breast examination, which aids in helping to detect and find breast cancer or other abnormalities.

NOTE: *The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings.*

A screening pelvic examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge.

AND

- Digital rectal examination including for sphincter tone, presence of hemorrhoids, and rectal masses.
- Pelvic examination (with or without specimen collection for smears and cultures) including:
  - External genitalia (i.e., general appearance, hair distribution, or lesions)
  - Urethral meatus (i.e., size, location, lesions, or prolapse)
  - Urethra (i.e., masses, tenderness, or scarring)
  - Bladder (i.e., fullness, masses, or tenderness)
  - Vagina (i.e., general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele)
  - Cervix (i.e., general appearance, discharge, or lesions)

- Uterus (i.e., size, contour, position, mobility, tenderness, consistency, descent, or support)
- Adnexa/parametria (i.e., masses, tenderness, organomegaly, or nodularity)
- Anus and perineum

Coverage for the pelvic screening examination is provided as a Medicare Part B benefit. The coinsurance or copayment applies for the pelvic and breast examinations. There is no Medicare Part B deductible.

Coding and Diagnosis Information

Medicare-covered pelvic screening examination services are billed using the following Healthcare Common Procedure Coding System (HCPCS) code:

HCPCS Code	HCPCS Code Descriptor
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination.

Table 1 - Procedure Code for the Pelvic Screening Examination Service

Diagnosis Requirements

When a claim is filed for a screening Pap test and/or pelvic screening, one of the screening ("V") diagnosis codes listed in Table 2 must be used. Code selection depends on whether the beneficiary is classified as low risk or high risk. This diagnosis code, along with other applicable diagnosis codes, is also reported. Failure to report the V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

ICD-9-CM Codes	ICD-9-CM Code Descriptors
V76.2	Special screening for malignant neoplasms; Cervix; Routine cervical Papanicolaou smear. *Excludes: that as part of a general gynecological examination (V72.3)*
V76.47	Special screening for malignant neoplasms; Other sites; Vagina; Vaginal pap smear status-post hysterectomy for non-malignant condition. Use additional code to identify acquired absence of uterus (V45.77). *Excludes: vaginal pap-smear status-post hysterectomy for malignant condition (V67.01)*
V76.49	Special screening for malignant neoplasms; Other sites.
V15.89	Other personal history presenting hazards to health; Other specified personal history presenting hazards to health; Other.

Table 2 - Pelvic Screening Diagnosis Codes

Billing Requirements

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, HCPCS code G0101 and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

The screening pelvic examination service may be billed to an FI by the technical component category, which is defined as services rendered outside the scope of the physician's interpretation of the results of an examination, or the professional component category, which is defined as a physician's interpretation of the results of an examination.

When submitting claims to FIs, HCPCS code G0101, the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

As required by CMS, there are five specific bill types that are applicable for a pelvic examination screening [and two additional bill types in limited situations within Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)]. The applicable FI claim Types of Bills (TOBs) and associated revenue codes for the pelvic screening service are:

Facility Type	Type of Bill	Revenue Codes
Hospital Outpatient	13X, 14X	0770
Skilled Nursing Facility (SNF) Inpatient Part B	22X	
SNF Outpatient	23X	
Critical Access Hospital (CAH)*	85X	
Rural Health Clinic (RHC)	See Additional Billing Instructions for RHCs and FQHCs to follow.	
Federally Qualified Health Center (FQHC)		

Table 3 - Facility Types, Types of Bills, and Revenue Codes for Pelvic Screening Services

***NOTE:** Method I - All technical components are paid using standard institutional billing practices. Method II - Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

Coding Tips

A screening Pap test and a screening pelvic examination can be performed during the same encounter. When this happens, both procedure codes should be shown as separate line items on the claim.

The same physician may report a covered Evaluation and Management (E/M) visit and code Q0091 for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier -25 must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately during separate office visits.

Billing Requirements for the Technical Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the Carrier on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format) under the provider's practitioner number.

If the technical component of a screening pelvic examination is furnished within a provider-based RHC or FQHC, the base provider bills the FI under bill type 13X, 14X, 22X, 23X, or 85X, as appropriate, using the provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 0770.

NOTE: Independent RHCs and Freestanding FQHCs are freestanding practices that are not part of a hospital, Skilled Nursing Facility (SNF), or Home Health Agency (HHA). Provider-based RHCs and FQHCs are integral and subordinate parts of hospitals, SNFs, or HHAs, and under common licensure, governance, and professional supervision.

Billing Requirements for the Professional Component for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

When the professional component of a screening pelvic examination is furnished within an RHC/FQHC by a physician or qualified non-physician, it is considered an RHC/FQHC service.

RHCs and FQHCs will bill the FI under bill type 71X or 73X, respectively, for the professional component, along with revenue code 052X.

NOTE: Effective April 1, 2005, RHCs and FQHCs will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Also, CMS is eliminating the special HCPCS coding for independent and hospital-based FQHCs billed on TOB 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter, 052X, or 0900/0910. For further instructions, see CR 3487, transmittal 371, dated November 19, 2004, Updated Billing Instructions for RHCs and FQHCs.

Reimbursement Information

General Information

Medicare provides coverage for the pelvic screening examination as a Medicare Part B benefit. The coinsurance or copayment applies for the pelvic and breast examinations. The Medicare Part B deductible does not apply.

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at *www.cms.hhs.gov/physicians/cciedits* on the CMS website.

Reimbursement of Claims by Carriers

Reimbursement for the screening pelvic examination service is based on the Medicare Physician Fee Schedule (MPFS).

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for the screening pelvic examination service depends on the type of facility. Table 4 lists the type of payment that facilities receive for pelvic screening examination services.

If the Facility Is a...	Then Payment Is Based On...
Hospital	Outpatient Prospective Payment System (OPPS)
Skilled Nursing Facility (SNF)	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospital (CAH)	Reasonable Cost Basis
RHC	All-inclusive rate for the professional component Provider's payment method for the technical component
FQHC	

Table 4 - Types of Payments Received by Facilities for Pelvic Screening Examination Services

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of Pelvic screening:

- A beneficiary who is not at high risk has received a covered Pelvic Screening within the past 2 years.
- A beneficiary who is at high risk has received a covered Pelvic Screening during the past year.

To obtain Carrier and FI contact information please visit *www.cms.hhs.gov/contacts/incardir.asp* on the CMS website.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at *www.wpc-edi.com/Codes* on the Web. Additional information about claims can be obtained from the Carrier or FI.

Written Advance Beneficiary Notice (ABN) Requirements

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary, before he or she receives specified items or services that otherwise might be paid for by Medicare, that Medicare probably will not pay on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit *www.cms.hhs.gov/medicare/bni* on the CMS website.

Frequently, there is confusion regarding whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services. In making this decision, the provider/supplier first must determine whether the item or service meets the definition of the Medicare-covered benefit. If the item or service does not meet the definitional requirements for the Medicare-covered benefit, then the item

or service will never be covered by Medicare. As a result, the beneficiary will always be liable for the cost of the item or service, and an ABN is not needed to shift liability to the beneficiary.

If the item or service meets the definition of the Medicare-covered benefit, Medicare still may not pay for the item or service if the item or service was "not reasonable and necessary" for the beneficiary on the occasion in question or if the item or service exceeds the frequency limitation for the particular benefit or falls outside the applicable time frame for receipt of the covered benefit. In these instances, an ABN may be used to shift liability for the cost of the item or service to the beneficiary. If an ABN is not issued to the beneficiary, the provider/supplier may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not reasonably have been expected to know that Medicare would not pay for the item or service.

Pelvic Screening Examination

Resource Materials

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule and OPPS.
www.cms.hhs.gov/providers

Medicare Learning Network
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare providers. For additional information visit the Medicare Learning Network's Medlearn web page at *www.cms.hhs.gov/medlearn* on the CMS website.

Preventive Services Educational Resource Web Guide
www.cms.hhs.gov/medlearn/preventiveservices.asp

The American Cancer Society, Inc. January 1, 2004. *Detailed Guide: Bladder Cancer* [online]. Atlanta, GA: The American Cancer Society, Inc., 2004 [cited 1 October 2004].
www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_bladder_cancer_44.asp?rnav=cri

National Cancer Institute
www.nci.nih.gov

Beneficiary Notices Initiative Website
www.cms.hhs.gov/medicare/bni

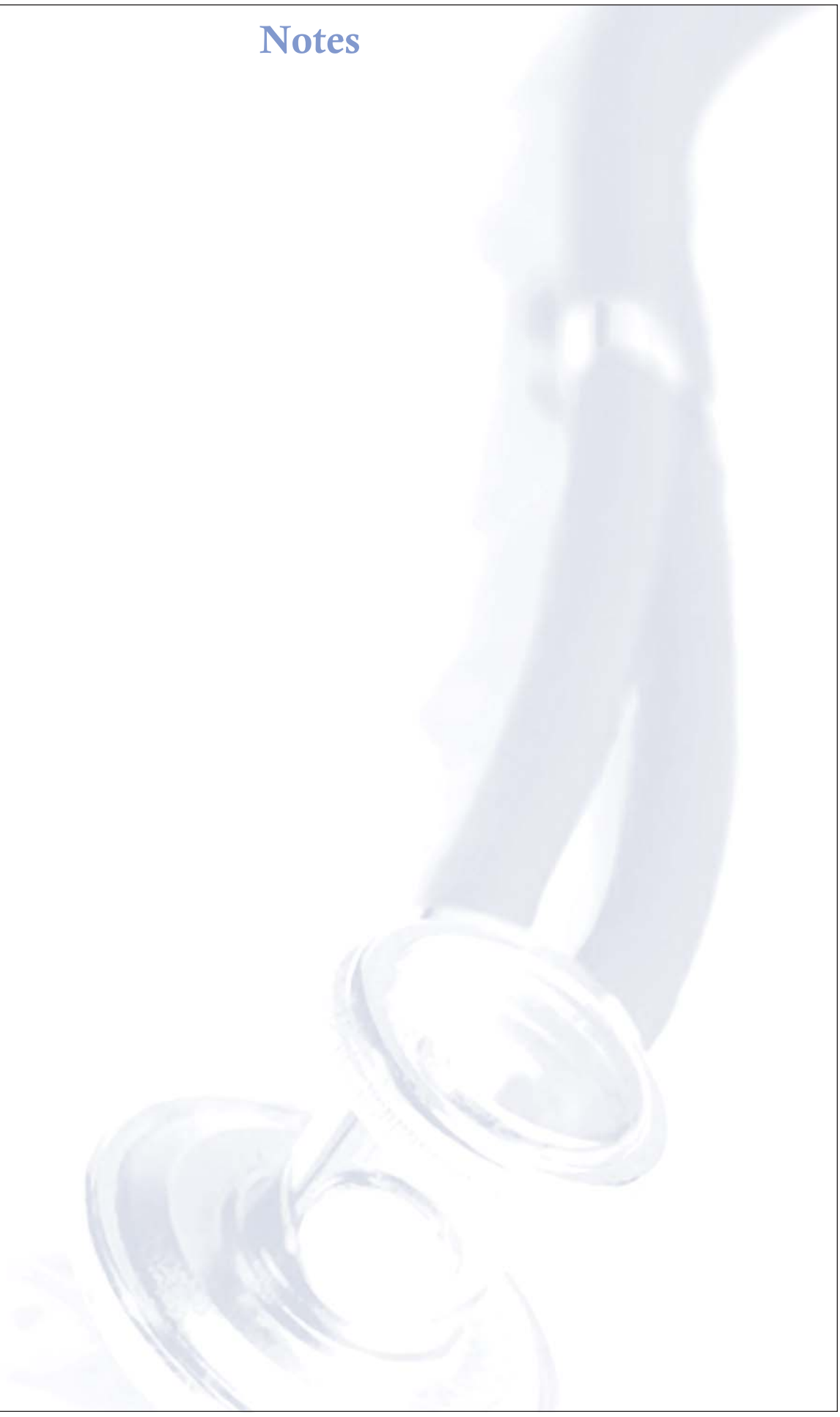
Carrier and FI Contact Information
www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website
www.cms.hhs.gov/physicians/cciedits

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference D of this Guide.

Notes



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